STARH Issues Paper

Improving Service Quality through Accreditation

November 2001

Jakarta, Indonesia

The STARH (Sustaining Technical Achievements in Reproductive Health) Program is a three-year project funded by the U.S. Agency for International Development under Cooperative Agreement No. 497-A-00-00-00048-00, effective August 22, 2000. The project is implemented by Johns Hopkins Center for Communication Programs, Johns Hopkins Program for International Education & Training in RH, John Snow International, Yayasan Kusuma Buana and PT. Manggala Jiwa Mukti.

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Acknowledgments

In support of the BKKBN New Era Strategy and its focus on improved quality and choice in reproductive health service delivery programs, the STARH program has produced this publication on program design for quality certification. The aim of this document is twofold. First, in general terms, it lays out a range of options for designing the principle components of quality certification programs. Second, the publication highlights the challenges and opportunities specific to implementing a quality certification scheme in the Indonesian context.

In accordance with BKKBN's strategy to build mutually beneficial partnerships with a wide range of institutions, the authors of this publication met with Ministry of Health (MoH) program managers, at both central and local level, NGOs, professional organizations, donor agencies and service providers. Special appreciation goes to the staff of BKKBN Bandung Provincial Office; the staff of MoH Bandung District Office, Dr Haryoko, World Bank Consultant; Dr Rachmi Untoro, Director of Health Centre Development, MoH; Dr Nesim Tumkaya, UNFPA Country Representative and Pam Wolf and Carol Rice, USAID. The authors are particularly indebted to Dr Ardi Kaptiningsih, Head of the Sub-directorate for Family Planning, MoH, Pak Lalu Sudarmadi, Principal Secretary, BKKBN and the STARH staff.

Funding for this work was provided to JHU/CCP and JHPIEGO under Cooperative Agreement No. 497-A-00-00-00-048-00

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I. Introduction

There is increasing concern about the quality of health care in Indonesia. Since the Contraceptive Prevalence Rate is relatively high, organizations involved in the provision of family planning services are now focusing efforts on improving service quality. In their search for efficient strategies for achieving quality, the Indonesian Ministry of Health (DEPKES) and National Family Planning Coordinating Board (BKKBN) have expressed interest in developing and implementing primary health care accreditation models.

Quality improvement of reproductive health services is also one of the main objectives of the STARH Program. Whilst STARH is already addressing various aspects of quality, STARH is engaging partners in an active dialogue to explore accreditation model options and their implications and requirements, before embarking on the significant effort required in accreditation. The purpose of this issues paper is to outline key characteristics and options for accreditation models that can serve as a basis for further discussion between the STARH Program and its counterparts. It lays out the benefits and challenges other countries have experienced in quality accreditation and explores the opportunities and challenges for such an effort in the Indonesian context.

II. Overview of Accreditation Models

Accreditation is the assessment of a health care organization's compliance with pre-established performance standards. It is usually a voluntary process linked to incentive systems and part of a more comprehensive quality improvement and assurance effort. Accreditation typically uses external review and assessment of compliance with standards, focusing on organizational rather than individual performance. Although practically all accreditation models reflect these basic characteristics, there are several ways in which accreditation schemes can be tailored to meet the needs of a given programmatic context. Below are descriptions of a range of options in twelve different aspects of the accreditation design and implementation processes (for a summary see Annex 1).

a) Purpose

One of the first steps in designing an accreditation model is to arrive at consensus on the goal of the accreditation initiative. Defining the overall purpose is a prerequisite for determining things such as the potential life span of the accreditation effort. The goal or purpose can range from a relatively short-term promotion of a specific type of service (e.g. the Baby Friendly Hospital initiative), to a longer-term, institutionalized process that focuses on assuring consistent compliance with quality or regulatory/legal requirements of health care provision. The latter option can be linked to establish health insurance (public or private) financing schemes. An intermediate option is an accreditation process that serves as a mechanism to improve performance and service utilization as seen in models like the Egypt Gold Star or Brazil PROQUALI.

b) Type of Standards

The greatest level of detail in standards is reflected in those focusing on structure and process, which include the inputs required for quality care, as well as the steps followed during the provision of care. More detailed sets of standards for inputs and processes are typically required when basic infrastructure elements are not in place and the technical competence of the staff is substandard due to deficient pre-service training or introduction of new procedures. Outcome standards, which define the results of the care provided, are usually less detailed but frequently more difficult to assess and monitor. There is also the risk that some outcome standards are influenced by external factors and might not accurately represent the actual quality of care provided.

c) Definition of Standards

There are a variety of approaches to define standards. Accreditation standards usually incorporate evidence-based technical norms and protocols. This may happen in a top-down process in which standards are defined at a central level by groups of experts in relevant fields. Standards, on the other hand, could also be developed based on client preferences and definitions of quality as explored through qualitative or quantitative market research methods. This latter approach is less common but is useful because it helps set the stage for increased levels of community involvement and ownership in quality initiatives. Increasingly, however, accreditation standards are developed using a combination of these two approaches in combination with additional input from the perspective of the front-line provider. The West Africa Gold Circle and PROQUALI models both reflect this approach.

d) Incentives: Positive and Negative

Another essential aspect of accreditation is the design of a sustainable, yet meaningful incentive and consequence scheme. Some accreditation models exclusively use non-monetary incentives such as public recognition, performance feedback and skill building opportunities. Others build in additional incentives like provision of equipment, increased operational budgets for the facility or even small monetary rewards. Finally, some models focus on monetary incentives provided through performance-based budget allocations and/or service remuneration systems. The latter are often linked to health insurance finance schemes. In addition to using accreditation to encourage desired practices, it can also use disincentives that serve to discourage undesirable practices. For instance, if a facility or an individual provider fails to perform as required by standards, negative consequences (administrative, economic, or even legal) could follow.

e) Unit of Accreditation

While the unit of accreditation may be individual providers, this is often referred to as certification. Accreditation might focus on one type of health facility within the health system. For instance, if the overarching objective of the initiative is to strengthen reproductive health care practices in primary health care, the focus of accreditation is likely to be only on primary care clinics. Other models include multiple types of facilities in order to ensure an effective continuum of care. For example, the Gold Star program in Egypt includes family planning clinics in a variety of facilities ranging from large urban hospitals to rural health dispensaries. It is important to note that even in models in which the accreditation unit is a facility and not an individual, facility staff and providers are still often recognized for their contributions to the overall facility performance.

f) Range of Services

The range of services included in an accreditation strategy can vary significantly. Based on institutional priorities and resource availability, it may be necessary to restrict the process to one type of service or related function. Examples of this focused accreditation approach have been implemented for quality improvement in family planning services, infection prevention practices, or promotion of breastfeeding. Sometimes, however, it is programmatically difficult to completely focus on only one isolated type of service. For example, in the Brazil PROQUALI initiative, a core set of quality standards for family planning were complemented by other standards for selected reproductive health services such as cervical cancer control, prevention of STIs, and anti-natal care. Another option is to include a comprehensive range of health services or all services provided at a given facility-level (i.e. Canadian Council on Health Services Accreditation).

g) Sectoral Coverage

Many accreditation programs in developing countries are restricted to one sector of health care provision be it public, private-for-profit or NGO. For example, the Guatemalan Ministry of Health has introduced a model that accredits NGOs that provide primary care services. These accredited NGOs receive government financial support that serves to expand coverage in underserved areas of the country. Another option for sectoral coverage is quality accreditation for more than one sector. In the West Africa Gold Circle accreditation scheme, both Ministry of Health and NGO clinics are assessed and accredited based on one set of criteria. In other instances, different but complementary accreditation strategies may be implemented across sectors using different sets of standards. A third option is to apply one set of criteria and processes across all sectors providing health services.

h) Geographical Coverage

Accreditation strategies range from very localized to national levels of coverage. A locally implemented strategy might focus on one or more districts in a selected number of provinces. This is appropriate when a particular model of accreditation is being tested with the intention of scaling up later. Other models seek greater coverage and are implemented on a regional, state, or provincial scale. This option is relevant in decentralized environments where provincial or state units have significant levels of political, technical and administrative decision-making power. Schemes implemented for national coverage throughout a given country may be linked to nation wide health provision and financing schemes. Models that are more local in scope might require adaptation of national level standards to local realities.

i) Management

An effective accreditation program requires planning, coordination, technical, administrative and financial support. These functions could be performed centrally, from one managerial unit, as in the case of the Gold Star program in Egypt, or in a decentralized system where managerial functions are devolved to the regional, provincial or district level. In the latter case, local authorities (state/provincial secretaries of health, or district/municipal mayors or secretaries of health) assume control of the process or have significant responsibilities and are largely involved in the design, planning, and implementation of the accreditation initiative. The central, provincial, and district levels can also jointly manage the accreditation program.

j) Accreditation Body

The group of people who assess performance and grant accreditation can be either internal or external to the institution that owns or manages the unit being assessed. Sometimes, there is a

single group that collects performance data and analyzes it to determine if it meets the required standards. More commonly, however, these two functions are performed by two separate but linked entities. Use of internal accreditation bodies usually draws on institutional supervision structures and is part of an internal quality improvement effort. Other accreditation models seek to maximize objectivity of the assessment and use external assessors (e.g. Joint Commission for Health Services Accreditation and ISO 9000). An external accreditation body reinforces the credibility of the process and is particularly suitable for service provision that already operates under sophisticated health management and financing schemes. An intermediate option that increases the credibility of accreditation processes yet allows for closer follow-up in areas where standards are not met, is an accrediting body made up of a combination of internal and external assessors. When building such a group, one may choose to include a university faculty, members of professional associations, community and civil society representatives.

k) Staffing

Planning, coordination, and implementation responsibilities for accreditation may simply be added to existing responsibilities and tasks of a service delivery organization's staff. This is most feasible when the accreditation effort is small in geographic coverage, technically focused, and built upon internal supervision systems. However, when the accreditation program is more complex or an effective supervision system is not in place at the local-level, it is often necessary to have full-time staff dedicated solely to assessment activities. Similarly, external accreditation bodies such as the Joint Health Commission use consultants or have full-time staff dedicated to quality assessment tasks. Design of internal accreditation bodies might take a variety of forms depending on the complexity of the accreditation process and the availability of resources. They may use their own staff on a full, part-time or seasonal basis.

l) Process

An accreditation process may be limited to the verification of compliance with pre-established standards through an external review and assessment. In this case, if the standards are met, the accrediting body simply grants the accreditation to the facility. If the standards are not met, the reviewers provide detailed feedback on the status of the facility and identified performance issues. In addition to the review and feedback, other accreditation processes offer technical assistance on demand in order to overcome the shortcomings identified. Brazil's PROQUALI and West Africa's Gold Circle provide proactive support and follow-up to help the facilities successfully perform at the level of accreditation standards. Approaches such as facilitative supervision or performance improvement are typically used in this facilitated accreditation process.

Benefits of Accreditation

Experiences in other developing countries have shown that well-designed and implemented accreditation processes usually result in improved quality of health services as defined by pre-defined standards. This is especially true when the accreditation scheme is integrated into a larger quality improvement and recognition program. In several cases, a significant increase in the utilization of health facilities has also been observed. Better health outcomes such as improved continuation rates for contraceptive utilization are another benefit of accreditation processes that increase client-oriented quality of services.

Accreditation processes also can improve organizational efficiency through the reduction of waste and better staff time utilization. The utilization of performance standards in accreditation

processes helps to streamline management and regularize supervision, including more timely and accurate identification of performance gaps. They can have a positive impact on provider motivation and satisfaction, especially when they include an effective combination of non-monetary and monetary incentives. Likewise, client satisfaction levels have shown to improve with the provision of more responsive, efficient and humanized care.

Finally, accreditation initiatives have served to draw the attention of local leaders and decision-makers to the important issue of health. In some instances, this has resulted in increased local investment of both financial and human resources to health-related efforts. This particular benefit of accreditation is especially relevant in the context of the decentralization processes currently being implemented in many countries around the globe.

Challenges of Accreditation

While there are multiple benefits of accreditation, implementation of an effective scheme presents several challenges, some of them significant. Accreditation initiatives that result in improved quality usually require additional resource investment up front. For instance, it is necessary to consider the costs of establishing and maintaining an operating structure for the accreditation process, staff and travel. The total amount of additional resources needed for a large scale or national accreditation and quality improvement initiative could be significant and sometimes unaffordable. It is extremely important to consider the amount of additional resources that would be needed and the potential sources of sustainable funding at the very beginning of the design phase of the accreditation effort. Periodicity of reassessments is one area that affects overall costs. While designers seek to establish an assessment schedule that provides frequent feedback to assure maintenance of quality levels, this can be modified to increase sustainability. Some models rely solely on public subsidies, while other programs build in fee collection for such costs as the accreditation assessments.

Gaining institutional involvement and commitment is another challenge. This is particularly complex when key stakeholders are not fully convinced of the potential benefits or consequences of the accreditation initiative. Reaching consensus on the design of the model to be implemented, on the standards for accreditation, and on the processes to be followed is a time-consuming and difficult task, particularly at the beginning of the process. Early agreement and clarity on the purpose of the accreditation effort will help facilitate these steps. This is critical because several of the changes required to improve quality are not under the control of the local facility but rather systemic.

The identification of meaningful, sustainable incentives and the establishment of consequences of performance are also critical and complex issues. It is not always easy to find the right combination of non-monetary and monetary incentives. Moreover, some incentives can potentially introduce distortions in the provision of health services. For instance, productivity incentives might discourage providers from performing important but time-consuming procedures.
It is a challenge to set standards at a level that are achievable and consistent with the objectives of the accreditation process. For example, less stringent requirements requiring only 90% compliance with standards for accreditation rather than 100%, can be established to enable higher success rates and promote change. More stringent requirements are typically necessary for strict quality assurance or regulatory purposes.

The elaboration of practical and simple tools for large-scale replication of accreditation models is one component in particular that requires a significant time commitment. The development of

such tools frequently requires technical expertise and also a critical review of current paradigms of health service provision and quality improvement.

Finally, because accreditation initiatives are often part of a more comprehensive quality improvement and assurance effort, they frequently require a substantial organizational change. Some of the required changes could result in modifications to the supervision system and shifts in power across the health system. Lead stakeholders' steadfast commitment to a larger vision of quality and ability to successfully manage complex change processes is critical for the achievement of the goals of any accreditation program.

III. Opportunities for Accreditation in the Indonesian Context

The relatively nascent culture of quality in Indonesia has created a level of awareness and interest in quality service provision that is prerequisite for the success of an accreditation strategy. Leadership at various levels within DEPKES and BKKBN express a clear commitment to improving service quality. Evidence of this commitment is clear in the numerous interventions to support quality improvement (e.g. training of providers, developing norms of facilitative supervision, orienting staff in quality assurance, etc.). The information presented below outlines specific characteristics of the Indonesian context that would facilitate the implementation of an accreditation strategy. The observations in this section and the following section on challenges in the Indonesian context are based on discussion with central-level stakeholders from DEPKES, BKKBN, NGOs and CA staff. They also reflect the perspective of a small sample of program and clinic managers in Bandung, West Java and Jakarta.

Interest in Accreditation as a Quality Improvement Strategy

Overall, leaders in DEPKES, BKKBN and family planning service delivery NGOs express great interest in implementing a quality accreditation scheme in reproductive health. While there are ongoing efforts to improve quality, decision-makers in these organizations recognize that key performance factors such as motivation and reward for good performance are not effectively being addressed. The recognition and quality demand generation interventions used in some accreditation models are very appealing to them.

Previous Experience with Accreditation

While levels of understanding of accreditation vary among institutional leadership and technical staff, there is a general familiarity with the concept of accreditation. A handful of accreditation initiatives have already been tried in Indonesia. While some are ongoing (e.g. hospital accreditation), others have not proven sustainable. A full quality improvement and accreditation scheme for primary health care has been developed in the most recent health project funded by the World Bank. This quality improvement process has been implemented in a limited geographic area, but the accreditation process still remains to be operationalized. DEPKES staff have requested that this effort be continued under the next World Bank health project and see it as a complementary activity that would facilitate the establishment of an accreditation program in family planning. The hospital and primary health care accreditation systems, along with other more focused quality improvement and performance-monitoring initiatives, can serve as building blocks and valuable sources of lessons learned for future accreditation efforts.

Existence of Complementary Efforts

Accreditation of service delivery in resource poor environments often requires a facilitative approach that is part of a more comprehensive strategy to improve and recognize quality. Other elements of quality improvement schemes are already in place in select geographical regions of Indonesia. Currently, a UNFPA funded project is working with DEPKES supervisors to build skills and establish more facilitative supervision processes. Under STARH, self and peer assessment models will be tested in various contexts. Not only are these interventions serving to build quality now, but they could also be incorporated for replication in the design of a facilitative quality accreditation process.

Decentralization

With the devolution of financial and administrative decision making to local government and parliament, there is concern about the level of resources that will be allocated to the health sector. Health program managers at various levels are looking for ways to ensure availability of resources necessary to provide quality services. An accreditation scheme with a strong quality recognition component could serve to empower communities and providers and increase the visibility of health service needs for the leverage of local resources.

Increased Autonomy at the Facility-Level

An experimental model of self sufficient puskesmas is being tested in Jakarta. The model is based on the successful Hospital *Pasar Rebo* experience where all income generated at a given facility is retained and managed by hospital administrators with the intention of creating a system of financial self sufficiency. In this case, service provision can be adjusted to generate income through two ways: the facility can negotiate service provision and payment agreements with health insurance organizations; they are allowed to raise fee scales for limited times during the day to cater to clients willing to pay more for benefits such as shorter waiting lines. The staff at one experimental *puskesmas swadana* were keenly aware of the role quality of care played in their ability to attract more paying clients and expressed a strong desire to find more effective means of improving quality.

Strong Field Presence

Accreditation in the context of decentralized health systems can be greatly enhanced when the community is effectively engaged. Community involvement in performance feedback mechanisms and identification of problems and solutions can contribute significantly to the success of accreditation. BKKBN's strong field presence would enable effective collaboration between providers and communities to pool resources and coordinate efforts in quality improvement and recognition. DEPKES also has a new initiative to develop community health councils (Badan Penyantun Puskesmas) that presents another channel of effectively engaging the community in quality improvement.

IV. Challenges for Accreditation in the Indonesian Context

Design and implementation of accreditation strategies require a significant investment of resources. While an accreditation strategy can be designed to minimize resources costs, the initial time and financial investment should not be underestimated. Below are the most important

challenges to implementing a quality accreditation scheme for family planning or reproductive health in Indonesia.

Institutional Coordination

Given the essential role of BKKBN and DEPKES in designing and implementing an accreditation scheme, it is critical that the two institutions collaborate effectively. Additionally, professional medical organizations will need to play a role as they fulfill their mandate of establishing standards for medical education and regulations for clinical practice. Early on, stakeholders from these three groups would need to achieve consensus on the role and responsibility of each institution in terms of: 1) accreditation scheme design, 2) implementation, 3) performance assessment and 4) follow-up. While it is generally recognized that collaboration between BKKBN and DEPKES can at times be challenging at the central level, there appears to be examples of effective working relationships at the provincial and district level. This particular issue may influence decision making regarding the level at which an accreditation scheme should be developed and implemented.

Credibility

The level of sophistication in quality improvement efforts across sites and geographical regions is varied throughout Indonesia. There are examples in Jakarta of health center management teams with a clear vision of how their health center will provide quality services in a financially sustainable manner. Although they still receive some government subsidies, the policy environment has changed to enable these forward-looking managers to link with insurance schemes and attain full autonomy from DEPKES in the area of financial planning. Their exploration of means to achieve this vision of sustainable quality service provision has raised awareness of international quality certification schemes such as ISO 9000. (ISO 9000 consists of a family of standards for a quality management system for any type of organization and was developed by the International Organization for Standardization – an international federation of national standards bodies from 140 different countries.) The desire for internationally recognized and credible accreditation processes may not be easily met by a scheme developed and implemented by domestic institutions using 'project-specific' approaches.

Establishment of Sustainable Incentive Mechanisms

The accreditation schemes implemented in Indonesia thus far have not had strong incentive mechanisms. In theory, the World Bank funded accreditation strategy will eventually provide financial incentives through links with health insurance schemes. To date, however, health insurance is only available to a limited portion of the population, which primarily includes civil servants, employees of large enterprises and individuals able to pay premiums on their own. If it is determined that the only sustainable incentive is recognition and promotion of quality, systems should be established to help manage a potential increase in client flow and work load so that high performers are not inadvertently punished.

Life Span of STARH Program

Other USAID-supported accreditation strategies have required relatively significant initial investments in financial and human resources. The process of achieving consensus on up-to-date standards of service, accreditation design, tools and processes can easily take a year or more. Initial testing of tools and implementation is time consuming and requires ongoing advocacy and

follow-up. It is critical to carefully consider the feasibility of committing to this investment in the remaining lifetime of the STARH project.

Changing Roles and Responsibilities in Context of Decentralization

As decentralization is implemented, roles, responsibilities and power will continue to shift. There is currently a high level of uncertainty as to how these issues will settle within institutions such as DEPKES. Likewise, the majority of budget allocations for health services and any related quality improvement efforts will no longer be controlled centrally. Simultaneously within BKKBN, the role of various cadres such as the PLKB is being redefined. In the context of such uncertainty, it will be challenging to embark on any large-scale accreditation strategy for some time.

Diversity in Indonesian Context

One of the primary principles of accreditation is that performance is assessed and recognized based on a standard set of criteria that are applied equally. Due to Indonesia's cultural, developmental and economic diversity, establishing one set of criteria that is achievable and meaningful across various types of facilities would be challenging.

V. Recommended Next Steps

Draft List of Recommended Next Steps for STARH supported Accreditation/Certification Scheme

Activity	Goal (s)	Who	When
1. Meeting of Core Stakeholders	1. Confirm commitment to accreditation scheme. 2. Achieve consensus on purpose of accreditation. 3. Consensus on phased approach by moving district-level implementation early – move quickly & avoid national scale consensus process. 4. Consensus on provinces/districts to be pursued for initiative. 5. Identify technical point people from these organizations who are available and have clear commitment to pushing this ahead. (e.g. steering committee?)	Key decision-makers in DEPKES, BKKBN, STARH, private sector partners & USAID	End of Aug
2. Explore Interest of Potential Districts with which to Work	1. STARH partners identify the focus-districts for participation in development and implementation of initial phase of QIR/accreditation	BKKBN, DEPKES and private sector	End of Sept
3. Accreditation/ Certification Workshop	1. Achieve common understanding of: a) basic principles of QIR/accreditation b) overall purpose c) design options 2. Arrive at consensus on major design components. 3. Define roles and responsibilities of each level.	STARH/DEPKES BKKBN/private sector Invite: Combination of decision- makers &technical staff from central, provincial and district-levels representing DEPKES, BKKBN, STARH, and other relevant NGOs and donors.	October
4. Conduct Client-Defined Quality Research	1. Conduct community/client-based qualitative research in sample of proposed district to gather community/client definitions of quality.	BBKBN/STARH/ Private sector partners	October

5. Indicator & Tool development	1. Review QIQ indicators to determine if any alterations or additional indicators needed to meet basic purpose and design elements of Indonesia accreditation scheme and ensure community definitions of quality are measured. 2. Determine the tools that will need to be developed (e.g. updated standards, protocols, self-assess. checklists, adapted QIQ monitoring tools, etc.) 3. Identify people to lead development and pre-test each tool and establish timeline and process for doing so.	Steering Committee and others as appropriate	November-December
6. Communication/ Recognition Strategy Meeting	1. Review communication strategies used in other accreditation/certification schemes. 2. Identify people to lead strategy development and related tools (to include media and community based activities) and establish timeline and process for doing so.	Steering Committee and others as relevant	November-December
7. Accreditation/ Certification Workshop II	1. Update larger group of stakeholders in progression with above step & elicit feedback/input. 2. Establish minimum standards for selecting focus service delivery sites. 3. Delineate next steps for selecting sites, beginning quality improvement and demand generation activities.	Steering Committee and Provincial/ District Reps Invite: Participants of Accreditation/ Workshop I and others as relevant	February

Annex 1

Options for Accreditation Model Design and Implementation

Aspects to be considered	Range of Options		
1. Purpose	Promote specific service	Improve performance & utilization of service	Ensure consistent level of quality/meet regulatory standards
2. Type of Standards	Inputs/structure/ process (more detailed)	Combined	Outcomes (less detailed)
3. Definition of Standards	Technically defined	Combined	Client-defined
4. Incentives & Consequences	Recognition	Recognition, monetary, equipment, etc.	Income/monetary
5. Unit of Accreditation	Individuals	One type of facility in health system (e.g. puskesmas)	Multiple types of facilities (e.g. hospital and puskesmas)
6. Range of Services	Focused (E.g. FP, IP, adolescents,)	Core set of services plus selected others	Comprehensive
7. Sectoral Coverage (public vs. private)	One sector	Varied by sector	Cross-sectoral
8. Geographical Coverage	Local/District	Regional/Provincial	National
9. Management	Decentralized	Shared	Centralized
10. Accreditation Body	Internal	Combined	External/Independent
11. Staffing	Added to existing regular tasks	Seasonal, part-time	Full-time staff
12. Process	Limited to verification	Support on demand	Proactive follow-up and support

Annex 2

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